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TRIP REPORT NO. UKR-33

SECOND TECHNICAL ASSISTANCE TO SKOLE RAYON

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SUMMARY

Family practice physician Peter Cowley and health economist and Zdrav*Reform* Technical Deputy Marty Makinen followed up on Makinen's earlier (November 1995) trip to the pilot rayon of Skole, L'viv Oblast. Cowley assessed the four-to-five month refresher and residency training of family practice physicians at L'viv Medical University and the practice of family medicine in the field in L'viv City and in Skole Rayon. The training programs were found to be sound, with only small areas identified for improvement. Suggestions were formulated to encourage medical students and existing specialists to enter the family practice training by putting family practice on the same career and pay path as other specialties and shortening the time needed for advancing in category for those re-trained as family practitioners. The plans for expanding the family practice network and related reforms in Skole were examined and suggestions for modification were formulated and discussed with the Head of the Rayon and Oblast Health Administrations. The suggestions included how to support the reforms with performance-based pay (including simple, measurable criteria for setting bonuses), charging by-pass fees to patients not receiving referrals from community facilities, charging fees to patients for inappropriate home visits, and charging fees to foreign truck drivers for health services used. The performance-based pay mechanism rewards doctors for treating patients on an ambulatory basis, minimizing the need for costly hospitalizations, and rewards the conduct of preventive activities, as well. Makinen also followed up on the recommendations he made during his previous visit.

OBJECTIVES

The major objective of this trip was to assist further in the development of the family practice program in Skole Rayon. This was to be accomplished through completion of the following tasks (see Annex A for complete scope of work):

- Review of the family medicine training at L'viv Medical University and the family practices of City Hospital Number 1 and Polyclinic Number 2
- Assist with revision of the Skole strategic plan for the family medicine network
- Assist with identification of locations for additional family medicine points
- Assist establishment of alternative care facilities for "social" patients
- Assist development of performance-based compensation
- Liaise between the Oblast and Rayon Health Administrations on per capita financing
- Assist in the development of new revenue sources

BACKGROUND

The Intensive Demonstration Site (IDS) plan for Zdrav*Reform* in L'viv Oblast includes assistance to two "pilot" rural rayons, Zhovkva and Skole. Skole was selected as a pilot rural rayon because of the restructuring of services that had been conducted under the leadership of Rayon Chief Doctor Ivan Shchadei. Dr. Shchadei also is Chief Doctor of the Skole Rayon Central Hospital. The Zdrav*Reform* work with Skole is intended to help establish a model defined family medicine network, in part by assisting with the opening of two new primary care centers (PCCs).

The present trip was preceded by Makinen's visit in November 1995. That trip provided advice on immediate issues in Skole and identified many of the specific tasks for the current trip.

The restructuring of health services begun by Dr. Shchadei involves the creation of PCCs in communities scattered around the rayon. The PCCs are to be headed by doctors trained in family practice principles. The two PCCs in place to date (Oryava and Zhupany) resulted from the conversion of community hospitals to ambulatory facilities. In neither has the doctor had training in family practice principles. The head doctor at the community hospital (20 beds) in Zavadka, Dr. Myron Dashynych has gone through the refresher course. Dr. Shchadei has reduced the number of beds in the rayon, without closing other whole facilities. Skole is in the Carpathian Mountains, so communities can become isolated from one another during the winter months. The PCCs are intended to bring services closer to these communities and to improve the efficiency of care by reducing the need to refer patients to the rayon polyclinic or hospital. An issue concerning the closure of the community hospitals is what will happen to so-called social patients, frequently elderly people who have sought food, shelter, and low-intensity care in these hospitals. They may be literally left out in the cold by the reforms. Makinen suggested that something akin to nursing homes be created to serve the needs of these populations, allowing the community hospitals to be closed without causing undue harm to a vulnerable population.

L'viv Oblast Regulation No. 774 of September 25, 1995, and subsequent orders of the Oblast Health Administration (OHA) specify that all municipal and rayon health administrations are to begin implementation of "per capita" financing in 1996. This means that each health administration is to receive an allocation of funds as a pro rata share of the 1995 allocation according to the number of people it covers. Each health administration is to be given the freedom then to allocate these funds to facilities as it chooses. Makinen left several alternative recommendations for Dr. Shchadei to consider concerning implemetation of per capita financing in Skole Rayon at the end of his last visit.

ACTIVITIES

To provide assistance with the development of family medicine in L'viv, Makinen and Cowley met with L'viv Medical University, where family practitioners are trained; with urban health facilities in L'viv City, where family practitioners are employed; with health authorities and facility personnel in Skole Rayon, where a rural family practice network is being developed; and with the head of the L'viv Oblast Health Administration, Dr. Mykola Khobzey. In addition, Cowley and Makinen met formally and informally with John Stevens and Borys Uspensky of Zdrav*Reform*/L'viv; Zdrav*Reform* short-term consultants Annemarie Wouters (Abt/Bethesda) and Brad Else, who were in L'viv working on other tasks; and Marc Stone and Victor Omelchenko of Zdrav*Reform*/Kiev.

At L'viv Medical University, Makinen and Cowley met with the Rector, Dr. Michael Pavlovsky; the Chairperson of the Family Medicine Faculty, Dr. Evhenia Zaremba; and the Chairperson of the Management Faculty, Dr. Yaroslav Bazylevych. On two occasions Cowley made presentations to and answered questions from groups of 30-50 faculty and students in the Family Medicine Department (see Annex G for a press clipping on this). He made a similar presentation to a group of faculty and students assembled by the Management Department. Cowley explained how the family medicine practice where he works in Virginia operates, contrasting it with the situation in the former Soviet Union. Makinen supplied some details concerning financing. The question and answer sessions were quite lively (see Annex C for a list of questions asked following Cowley's presentations). At the end of the assignment, Makinen met again with Dr. Pavlovsky and Dr. Zaremba to report to them on the findings and recommendations concerning the family practitioner training programs and the proposed incentive pay program in Skole Rayon.

Makinen and Cowley visited the ambulatory family medicine center associated with L'viv City Hospital Number 1. It serves a part of the catchment area that is distant from the hospital. In addition to speaking to the staff of the family medicine center, Cowley and Makinen spoke to Head Doctor, Jemma Jafarova, and Chief Accountant, Svitlana Bychenko. The latter described the incentive pay system used in Hospital Number 1.

At Polyclinic Number 2, Makinen and Cowley met with the Head Doctor, Dr. Yevheny Palladic, staff, and medical students at Polyclinic Number 2, focussing on the family medicine practitioners. Again, Cowley made a presentation and answered questions (see Annex C for a list of the questions asked).

Makinen and Cowley made two trips to Skole Rayon. In the first visit they met twice with Dr. Ivan Shchadei, Rayon Head Doctor and his Deputy, Dr. Ihor Vitvitsky, and visited Zavadka Community Hospital, Skole Rayon Central Hospital, Oryava PCC, and Korchin Feldsher Point. Dr. Vitvitsky accompanied Makinen and Cowley on the facility visits. During the facility visits information was gathered about:

- what services are available and what kinds of people are served at the Rayon Central Hospital in Skole

- the effects of closing a small rural hospital (Oryava)

- the practice of a recent graduate of the family medicine refresher (Dr. Myron Dashynych in Zavadka; see a summary of his performance report in Annex F)

- what kinds of patients there are and what services are provided at a community hospital (Zavadka)

- what is expected when a feldsher point is to be converted to a primary care center (Korchin)

Cowley and Makinen returned to Skole after digesting the information gathered and formulating preliminary recommendations for the advancement of Skole's family medicine plans. These recommendations then were discussed with Drs. Shchadei and Vitvitsky. Some modifications were made as a result. Cowley and Makinen also attended the monthly meeting of all feldshers presided over by Dr. Vitvitsky. Dr. Vitvitsky gave an opening speech to the feldshers during which he did an excellent job of explaining the rationale behind many of the recommendations made by Cowley and Makinen.

After their initial visits to the family medicine practices in L'viv, L'viv Medical University, and Skole Rayon, Cowley and Makinen arranged a meeting with Dr. Khobzey. The purpose of the meeting was to inform him of the issues which would need legal-political backing and to sound him out about his take on them. The issues included minor changes to the family medicine refresher training program and protection of the solid residency training program; the incentive pay and salary-scale issues concerning family practitioners; and the possibility of instituting experimental user charges to affect patient behavior and generate modest additional revenues in Skole (see the Findings and Recommendations sections, below, for more detail).

FINDINGS

1. <u>Review of family practice programs at L'viv Medical University, Hospital Number 1 and Polyclinic #2</u>

The family practice program at L'viv Medical University is appropriate and extremely comprehensive in its current three-year format. The refresher course curriculum for the four-month refresher course also is appropriate, but could benefit from being lengthened by one month for rural practitioners who face special demands. In addition, the refresher course probably would benefit from more training on the screening of important adult disorders such as breast and colon cancer and the importance of risk factors like alcohol abuse, cigarette use and poor nutrition on diseases such as hypertension, lung cancer, etc. (See recommendations B.1 and B.2)

Dr. Pavlovsky said that a decision had been made in Kiev to make a number of cuts in medical education in response to the general financial crisis in the country. Among the decisions is to shorten all residency training for doctors from three years to 18 months, with the exception of the residency for family practitioners, which is to be shortened to two years. There will be a decrease in state-funded places in medical schools, though the schools are encouraged to market themselves to paying students, especially abroad. Refresher training in all specialties is to be lengthened.

At Hospital #1 ambulatory clinic the family practice trained physicians are treating a wide range of pediatric and adult patients making minimal referrals to the hospital for specialist care or admission. At Polyclinic #2, family practice trained physicians also were treating a range of patients, concentrating on internal medicine and pediatric patients, with sufficient backup from specialists at the polyclinic for other patients.

2. Assist with revision of the Skole strategic plan for the family medicine network

Skole Rayon has a plan to develop its family practice network by converting small rural hospitals to ambulatory primary care centers and upgrading feldsher points to similar primary care centers. The execution of the plan has begun with the closing and conversion of small hospitals at Oryava and Zhupany. The head doctor at the small hospital at Zavadka has completed the refresher training in family practice principles. It is planned to have the head doctors at Oryava and Zhupany do the refresher training in 1996. The Zavadka hospital eventually is to be converted to an ambulatory facility. Four feldsher points are scheduled for upgrades:

- Tulkholka in February/March 1996
- Korchin in April/May 1996
- Holovets later in 1996
- Krushelnitsa in 1997

The plan is sound. Two small weaknesses are the slow pace of refresher training for doctors to staff the primary care centers and the reluctance to convert the Zavadka hospital to an ambulatory center now. It is difficult to send many doctors to L'viv for the refresher training at a time, because it is hard to find interim replacements. A large share of the patients in Zavadka hospital could be treated on an ambulatory basis, but the tradition of having a hospital near by makes it difficult to close it.

3. Assist with identification of locations for additional family medicine points

As noted in point 2, above, the Skole Rayon Health Administration plan for opening additional primary care centers, staffed by doctors trained in family medicine is sound.

4. Assist establishment of alternative care facilities for “social” patients

In Makinen's previous assignment to work with the Skole Rayon health authorities, he had recommended that consideration be given to creating nursing homes to provide an alternative to hospitalization of so-called "social" patients, primarily elderly people who need food, shelter, medical monitoring, and low-intensity care. Makinen reviewed this concept with Dr. Shchadei in Skole. Dr. Shchadei said that nursing homes do not have a positive reputation with the public. They are seen as undesirable places to live and as places where people go to die. People are resistant to the idea of only periodic visits by doctors, as opposed to having a doctor constantly on site. People would prefer to stay at home, as opposed to going to nursing homes. Makinen suggested that if "social" patients would prefer to stay at home, then visits to them by feldshers would be a more cost-effective alternative than hospitalization or home visits by doctors. Further, if the nursing home approach were to be tried, it should differ from past Ukrainian experiences, by making the nursing homes more pleasant and the low-intensity medical care better, to try to overcome public resistance. Hence, the recommendation concerning nursing homes is repeated below with some elaboration. This is an item that may need some time to "incubate" with decision makers, before it is taken up, if it is taken up at all. It should be noted that there is a recognition among decision makers that it is desirable to keep "social" patients out of the hospitals. (See recommendation G.1)

5. Assist development of performance-based compensation

Two sets of issues related to compensation of family practitioners were taken up by Makinen and Cowley. One set of issues has to do with the incentives for doctors to enter into training in family medicine principles. The other set concerns incentives to perform the functions of family medicine on the job.

At this time there is little to motivate medical students to enter the residency in family medicine nor to motivate mid-career doctors to enter the refresher training. Nearly all of those who have entered these programs to date have done so because they were told to do so. Family medicine is recognized officially in Ukraine. However, it has not been included in the salary structure (no category at graduation from medical training, second after five years of experience, first after a total of seven years of experience, and highest, after a total of ten years of experience; with some refresher training and passing of an examination required for advancement to each category) used for all other recognized specialties. The first class of family medicine residents will graduate from the three-year program in July 1996. Without inclusion in the salary structure they may fall into a kind of pay limbo. (See recommendation A.1)

Those mid-career doctors entering the refresher training in family medicine are offered no financial incentive to do so. They retain the salary categorization of their original specialization, but are given no increase in category nor pay bonus. (See recommendation A.2)

Family medicine training graduates have been taught to treat a broad range of cases and all age groups. This should allow them to refer fewer patients for hospitalization or to specialists. They also are trained in many preventive activities (this is one area of the training that needs some strengthening, see above). This should result in fewer illnesses requiring treatment. However, in

practice some patients who could be treated by family practitioners are referred and some more effort could go to preventive activities. Family practitioners are paid a salary regardless of their performance in treating cases, rather than referring them, or in performing preventive activities.

Dr. Shchadei has wanted to institute a performance-related pay system in Skole. He has had in mind a set of criteria to use for judging performance (see Makinen trip report of November 1995). The criteria go in the right direction, but are complex and often would be difficult to attribute to an individual doctor's performance. For example, using mortality rates in catchment areas to evaluate primary care practitioners' performances would be difficult given differing age profiles of populations, differing epidemiological situations, and small absolute numbers of deaths. Cowley and Makinen developed some simpler criteria which would reward preventive activities and appropriate referrals, while discouraging inappropriate referrals (see tables in Annex B). When presented to him, the simplified performance criteria got a very positive response from Dr. Shchadei. (See recommendation C.1)

6. Liaise between the Oblast and Rayon Health Administrations on per capita financing

Makinen and Cowley met with Dr. Khobzey to sound him out about a number of legal-political issues, including changes to the family medicine refresher training and protection of the residency training; incentive pay and salary-scale issues concerning family practitioners; possible institution of experimental user charges to affect patient behavior in Skole; possible user charges to international truckers for health services; and Skole's plans to grant global budgets to its three largest hospitals. He was told that he might receive a request for permission to institute performance pay and fees for self-referral and home care from Skole. (See recommendations F.1, C.1, D.1, D.2, E.1, and H.1)

Dr. Khobzey had no objection to any of the possibilities raised, with the exception of the charges for international truckers. He noted that emergency care for all, whether national or foreigner, should be provided at no charge. He was skeptical that there would be any demand for non-emergency care by truckers passing through the rayon in about an hour's time. (See recommendation F.2)

Dr. Khobzey also noted that finding funds for use in performance pay was becoming tougher as unfilled positions were being eliminated (many of the performance-pay programs in L'viv provider institutions, such as the one at City Hospital Number 1, have been funded through salaries allocated for positions that were unfilled). However, he noted that the institution of family practitioners is intended to save resources through reducing referrals to specialists and hospitals, so in this way some supplementary funds may become available which could be used for paying incentives.

Finally, when the intent to award global budgets to hospitals in Skole was mentioned, Dr. Khobzey's reply was simply that per capita financing had begun, implying that Skole was free to institute such policies if it wished to do so. Later, these responses were communicated to Dr. Shchadei. (See recommendation H.1)

7. Assist in the development of new revenue sources

Makinen and Cowley discussed with Skole authorities the possibility of charging small (50-100,000 Koupons, or about US$0.25-0.50) fees for services provided to patients who self-refer to specialists and hospitals and to those able-bodied persons desiring treatment at home, and to charge bigger fees (around one million Koupons, or about US$5.00) to foreigners (usually trucker drivers) seeking non-emergency care. Only the charging of foreigners would have as its primary purpose raising additional revenues. The fees charged for home visits and self-referrals would be intended to change patient behavior (discouraging self-referrals and encouraging the able-bodied to come to primary care centers to see the doctor), more than to raise revenues. It was suggested that any revenues earned from these charges be put into improving patient care. The Skole authorities were warm to the behavior-altering charges, but somewhat cool to the idea of charging foreigners. (See recommendations D.1, D.2, and E.1)

8. Additional Findings

In both L'viv and Skole the understanding of how family practitioners can improve efficiency, quality of care, and responsiveness to consumers is as high as anywhere in the former Soviet Union. Further, there are real activities underway to apply the concepts, hence there is the opportunity to disseminate information about them to stimulate replication ("roll out"). (See recommendations I.1 and I.2) Despite this, some people in L'viv have some gaps in their understanding of the overall concept. Hence, in Annex D, an explanation of the concept of the role of family practitioners in the former-Soviet context is presented, using text and graphics.

RECOMMENDATIONS/FOLLOW-UP

A. Recommendations on stabilizing and improving the family practice trained physician salary structure:

A.1. Legalization of salary categorization for family practitioners

Currently, there is no legal or administrative framework for the provision of second, first, and highest salary categories for the family practice trained doctors (whether trained in the refresher course or by residency). To become more prevalent and to have their status confirmed in the medical community, at minimum, parallel salary categories to those for therapists (internists) and pediatricians must be formalized and guaranteed to family practice trained doctors.

A.2. Rewarding Refresher Training in Family Practice

To motivate mid-career doctors to enter the refresher training in family practice principles, consideration should be given to shortening the time for advancement in salary category by a year or awarding bonuses for those who complete the family practice refresher.

B. Recommendations regarding the family practice curriculum:

B.1. Improving the three year family practice residency program

The residency program as it stands now in its three year format is excellent and could serve as a model for much of the world. Neither the length nor the content of the internship program should be changed to any great degree. The following are minor suggestions that may make the program even better:

- Stress the family as a social unit by possibly introducing theoretical and clinical presentations by psychologists or psychiatrists familiar with the subject.

- Provide more training in the prevention of diseases by modifying risk factors such as smoking use and alcohol abuse.

- Highlight in the training program the importance of screening for consequential diseases such as breast, cervical and colon cancer. Increase the capabilities for interns to recognize early clinical signs of hypertension and diabetes. Since hypertension and diabetes are often diseases linked to risk factors such as a poor diet, training of residents in diet counseling for patients also is needed.

- Review risk factors for sexually transmitted diseases and instruct interns in the prevention and treatment of sexually transmitted diseases.

B.2. Improving the five-month family practice "refresher" program

The refresher program is also well thought out and excellent. The main recommendation is to extend the program a month for those physicians who practice or plan to practice in a rural area. These additional months training should include theoretical and practical education in the following: gynecology, obstetrics, minor trauma and neurology.

Other minor suggestions include the following:

- Stress the role of the family in such diseases as alcohol abuse or the avoidance of teenage pregnancies.

- Furnish more training in the prevention of diseases by modifying risk factors such as smoking use and alcohol abuse. Provide more clinical education in the areas of screening, recognition and avoidance of important diseases such as hypertension, diabetes and cancer (as detailed in the recommendations for the internship program).

C. Recommendations Concerning Incentive-Based Mechanisms to Affect Efficiency, Prevention Activities and Appropriate Referrals

C.1. Incentive based programs aimed at physicians can improve efficiency and quality of care

An incentive-based program could use a physicians traditional salary based on years of service and supplement this salary on a bi-annual basis with a bonus based on a point system. The point system must utilize indicators which are not only objective, but easy to measure and for which supporting records traditionally exist. In addition, points can either be added or subtracted depending on the activity and action as delineated below:

- For every fully immunized child recorded in official ledgers, the family practice physician will receive a point(s). While there is a risk of fraudulent ledgers, this could be confirmed by non-scheduled visits by a member of the incentive committee to the child s home for either written or verbal confirmation. The relative value of the points assigned to the physician for a fully immunized child as compared to appropriate referrals or preventive activities must be determined by the incentive committee.

- A prevention activity checklist such as outlined in Table 1 (in Annex B) could be introduced with the appropriate completion of the table awarded with positive points. Like vaccination rates, fraudulent checklists could be avoided by unscheduled visits to the family member named in the checklist. Again, the relative value of the points assigned to the physician for a fully completed prevention/screening checklist as compared to appropriate referrals or rates of fully vaccinated children must be determined by the incentive committee.

- Because the rate of hospitalization depends on many factors including the case mix of the population and caution must be expressed in using this indicator to make small differentiation between providers without case mix and socio-economic adjustments. Far simpler and more practical is to review each admission and referral by committee according to the matrix presented in Table 2 (in Annex B). Positive points (and therefore a larger bonus) would be applied to the referring physician's point total if the referral was appropriate; conversely negative points (smaller bonus) would be applied for an inappropriate referral. The number of points assigned to an appropriate referral for hospitalization versus the number of points for an appropriate referral to a specialist should reflect the higher cost of hospitalization relative to the cost per visit to the specialist. Finally, the point system based on referrals should reflect outstanding providers who consistently refer patients correctly, as compared to others in the rayon. These providers may be made eligible for even more positive points.

D. Recommendations Concerning Fees to Affect Patient Behavior

D.1. Charge a Small Fee to Ordinary Patients Requesting a Home Visit

Given the expense of fuel to travel to make home visits and the alternative uses of the doctor's time, the Rayon Health Administration should consider asking ordinary patients to make a small payment (on the order of 50-100,000 Koupons) for home visits by PCC doctors. Invalids and others categorized as privileged should be exempted from paying the charge. Those who come to the PCC for care should pay no fee. The proceeds of the fee and the money saved by making fewer home visits (saving in fuel expenditures) should be used to improve patient care, for instance to fund extra drugs for the elderly or children, the repair of basic laboratory equipment, the purchase of basic reagents, etc. The primary reason for the home-visit fee is to change patient behavior, not to raise revenues.

D.2. Charge a Small Fee to Patients Self-Referring to Skole Rayon Central Hospital and Polyclinic

To minimize self-referral to the Rayon Central Hospital and specialists at the Rayon Polyclinic a small fee (on the order of 50-100,000 Koupons) should be charged for those who do not obtain a referral from a family practice doctor. Self-referrals lead to medically unnecessary hospitalizations and consultations with specialists. Both of the latter are costly to the Rayon health system. The revenues from the fee should be used to improve patient care. Again, the major reason for the self-referral fee is to change patient behavior, not to raise revenues.

E. Recommendation to Raise Additional Revenue:

E.1. Charge Foreign Truck Drivers for Health Services

Skole health authorities should consider promoting the availability of health services to foreign truckers and charging substantial fees for them. Some of Skole's health facilities are located along international trucking routes. The truck drivers occasionally use Skole's health services (the Oryava PCC reports about one visit per month without any advertising of the availability of services). Advertising the availability of health services along the roads used by the truckers and charging fees above costs could yield moderately substantial additional revenues. A fee of approximately one million Koupons for a consultation, with additional charges for tests and procedures, would probably be attractive to the truck drivers who need medical attention en route, while generating revenues well above costs for Skole providers.

F. Recommendations Concerning Legal-Political Issues:

F.1. Request Permission or No-Objection for Experiments with Incentives and Fees

Dr. Shchadei should request permission or a statement of "no objection" from Oblast Health Administrator Khobzey to experiment with the payment incentive program for primary-care practices and for charging fees for self-referrals, home visits, and use of non-emergency services by foreigners. Dr. Shchadei may wish to promise to report on the effects of these experiments as a part of the request to Dr. Khobzey.

F.2. Support Skole Experiments, Incentives to Enter Family Medicine Training, and the Family Medicine Training Programs

Dr. Khobzey should provide the needed permission or "no objection" to allow Skole to go ahead with its initiatives on performance pay and fees. He should express his support to Ministry of Health officials in Kiev (e.g., Deputy Ministers Serdyuk and Kartysh) to the incentives recommended above to encourage doctors and medical students to enter family medicine training. Dr. Khobzey should use his office to defend and protect the strong residency and refresher training programs in family medicine principles at L'viv Medical University.

G. Recommendation Concerning Social Patients:

G.1. Reconsider Establishment of Nursing Homes and Home Visits by Non-Doctors to Serve "Social Patients"

Makinen's earlier recommendation to consider establishing nursing homes as an alternative to hospitalization of so-called social patients should be reconsidered. An alternative that may be pursued in parallel is strengthening home visits to social patients by non-doctor personnel. The public's perception that nursing homes are unpleasant places where people go to die may be reversible. Some former nurseries are available for renovation into alternative uses. They should be renovated well, staffed by a nurse or feldsher to provide low-intensity care and medical monitoring, heated, and regularly cleaned and maintained. Nutritious food should be prepared for residents. A doctor could be on call for the facility, as well as seeing patients for appointments regularly. Nursing homes of this type are used around the world as an alternative to hospitalization for "social" patients. For those able and preferring to stay at home, a program of feldsher or nurse home visits could be an alternative. In both cases, co-funding of the program could be sought from pension allocations of those housed in such facilities and community groups. Secular and religious groups may be willing to make cash contributions and in-kind donations of labor, food, etc.

H. Recommendation Concerning Implementation of Per-Capita Financing:

H.1. Global Budgeting for Hospitals

As per-capita financing of the Rayon's health system becomes a reality (later in 1996), consideration should be given to granting global budgets to the three large hospitals (more than 50 beds), Slav'ske, Verhne Synovydn, and the Rayon Central Hospital. Granting global budgets would mean that the head doctors would have the freedom to allocate the sum of money allocated for the year for their hospitals as they see fit among all competing uses, including salaries and staff bonuses, drugs, supplies, spare parts, equipment, and transportation. In return for this budget freedom, the head doctors would have to be responsible for the achievement of some indicators of performance. These might include:

- Low re-admission rates

- Low in-hospital infection rates, (for some common reasons for admission, such as pregnancy and ischemic heart disease)

- Low complaint rates

- Meeting a minimum threshold annual number of hospitalized days per 1,000 population

I. Recommendations Concerning Dissemination About Family Medicine in L'viv Oblast and Skole Rayon:

I.1. Publish Articles About Family Medicine in L'viv Oblast in Medical Journals

The accomplishments and plans of Skole Rayon merit the attention of the broad health community in former-Soviet countries. An article or articles about the training and use of family practitioners in L'viv Oblast could be prepared for submission for publication in journals like *Organization of Healthcare and History of Medicine* (*OHHM*). Potential topics and authors are the following:

- Training of Family Doctors - Dr. Zaremba and colleagues

- Family Doctors in an Urban Ambulatory Center - Dr. Jafarova and the staff of the City Hospital Number 1 Ambulatory Center

- Family Doctors in a Polyclinic - Dr. Palladic and colleagues at Polyclinic Number 2

- The Development of a Family Practice Network in Skole Rayon - Drs. Shchadei and Vitvitsky

The authors of this trip report would be willing to help with the writing of the articles, if desired. Victor Omelchenko of Zdrav*Reform*/Kiev has a contact with *OHHM* and may be able to help submit papers for publication.

I.2. Make a Video About Family Medicine in L'viv Oblast

Dr. Vitvitsky's excellent presentation to the feldshers of Skole, Peter Cowley's "evangelical" speech about family practitioners' role in health systems, Dr. Bazylevych's words about family medicine, Dr. Dashynych's explanation of the breadth of services he has learned to perform, both through the experience of serving an often-isolated rural community and through his refresher training at L'viv Medical University, Dr. Zaremba speaking about the training programs, and others could be filmed, then edited into a nice video to use in "rolling out" the concept of family practitioners. The use of the video for "roll out" could cover other rayons in L'viv Oblast, other oblasts in Ukraine, and other countries of the former Soviet Union (if made in a Russian language version in addition to the original Ukrainian).

LIST OF DOCUMENTS CONSULTED

"Hospital No. 2 Drug Formulary", John Kaufman, Zdrav*Reform* Program, Kazakstan, 1996.

"Essential Drugs for a Benefits Package", Peter Cowley, Zdrav*Reform* Program, Kyrgyzstan, 1996.

"Task/Product Flow Chart, L'viv Demonstration Site", Zdrav*Reform* Program, Revision 3, October 23, 1995.

"On Implementation of Per Capita Financing", Regulation Issued by the Head of L'viv Oblast Administration, September 25, 1995.

"Statistics Reference Book", L'viv Oblast Health Administration, 1995.

“Trip Report: Technical Assistance to Skole Rayon”, Marty Makinen, Zdrav*Reform* Program, November 1995.

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Brad Else, Consultant, Accounting Advisor

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Marc Stone, Director
Victor Omelchenko, Medical Advisor

ANNEX A

SCOPE OF WORK

ANNEX B

TABLES

ANNEX C

QUESTIONS ASKED BY AUDIENCES AT PRESENTATIONS ON THE ROLE OF FAMILY DOCTORS

13 February 1996
Emergency hospital -Family Medicine Faculty and Students of the L'viv Medical University
Dr. Evhenia Zaremba, Department of Family Medicine of L'viv Medical University, B. Uspensky, J. Stevens, P. Cowley
Questions :

1. What is the relation of the family medicine an insurance companies in the USA ?
2. How many patients does one FD cover ? Do physicians live in their catchment area ?
3. What is the training for the family practitioner in the USA ?
4. What responsibility does FD bear for malpractice ?
5. How are F'S paid ?
6. What documents are F'S required to keep ? What records do they keep ?
7. Does a FD employ any assistants ?
8. By whom and how is health promotion done ?
9. Do you have recourse if patients don`t follow advice ?
10. Can an insurance company penalize patients for poor health ?
11. Can an insurance company refuse to insure overweight diabetics ?

14 February 1996
Policlinic 2, Dr. Polotaiko, Dr Bazylevich, Faculty, M.Stone, P. COWLEY, 6th year medical students who are on practice in policlinic.

1. What training do you need to become a family practitioner ?
2. What is appealing about the FD practice in the USA ?
3. What equipment do you have ?
4. Who does tests and X-rays ?
5. Do you work on call ?
6. What documents do you keep ?
7. What happens if a patient falls ill during the night ?
8. Approximately how much time do you give to a patient ?
9. Are there lines of patients waiting ? Approximately how long does a patient wait ?
10. What training do you need to become a family practitioner ?
11. Does any form of FD re-training exist ?
12. Is the choice of specialization made voluntarily ?
13. Is it voluntary to study for the recertification exam ?
14. Who is responsible for patients' health ?
15. How long are refreshers to re-specialize as family practitioners ?
16. Does government finance training programs ?
17. What is the monthly salary of the FD as compared to other specialists ?

21 February 1996
Dr. Bazylevich, Chair Department of Management of LMU, Group of Faculty, Head Doctors (about 27 people) , students in Management and Marketing (all are doctors)

1. What training is required to be a FD ?
2. What equipment do you have at your office ?
3. What lab tests do you do ?
4. Do you use computers ? Do you keep patient records and payment information in the computer?
5. Do you own the equipment ?
6. What equipment can you personally use ?
7. What documentation do you keep ?
8. What percentage of your patients are insured ?
9. Who is responsible for prevention ?
10. What happens when the physician is ill or away ?
11. Is there an epidemic control for TB, AIDS, and other infectious diseases ?
12. Is there an epidemic control for cancer ?
13. What kind of surgeries do you perform ?
14. Does continuing medical education exist in the USA ?
15. Who can disqualify a FD ?
16. Is there mandatory treatment for drug addicts ?
17. How are F'S taxed ?
18. How is family medicine promoted ?
19. How do you handle infectious diseases ?
20. How do you evaluate FM potential in Ukraine ?
21. Do you have to do scientific work ?

21 February 1996
Emergency Hospital
Dr. Zaremba, group of Practicing Family Doctors, Students, Faculty.

1. Do you have any days off ?
2. What is your accounting and record keeping like ?
3. Who controls family practitioners ?
4. What about statistics ?
5. How do you do diphtheria inoculation ?
6. What legal framework is there for family medicine in the USA ?
7. When you have an interesting case, do you share it with others ?
8. How often do you read specialized literature ?
9. Do you have refresher courses ?
10. What kinds of exams do you have to pass ?
11. Do you meet with other doctors to discuss cases ?

ANNEX D

BRIEF ON THE ROLE OF FAMILY DOCTORS

Introduction Family practitioners can help make the health system more efficient and responsive to consumers, while maintaining or improving quality of care. These outcomes can be achieved when family practitioners emphasize prevention, treat a maximum share of patients, and, as a consequence, refer patients relatively rarely to specialists and hospitals.

Former-Soviet Context In former-Soviet countries, like in many other parts of the world, an over-reliance on specialists and hospitalization has developed. This has meant that many resources have had to be devoted to health services and that patients have been treated in hospitals, rather than on an ambulatory basis. Specialists in internal medicine (therapists) and pediatricians often are the first point of contact by patients. They treat the patients who fall clearly within their areas of medical expertise, but refer any who may benefit from a specialist's care or hospitalization. There have been no incentives for first-contact doctors to do otherwise.

Save Resources and Meet Patient Preferences The training of family practitioners allows them to treat a broad range of illnesses in all age groups. Further, emphasis in training of family practitioners is put on preventive activities, such as screening for breast and cervical cancers; childhood immunizations; and counseling about alcohol, tobacco, and drug abuse and good nutrition. The practice of family medicine then allows the doctor to refer fewer patients to specialists and hospitals and results in fewer people becoming ill. Since specialists and hospitals are more costly than family practitioners, a savings results. Prevention of illness also is less costly than treatment, and early treatment is less costly than late treatment. Further, people in many countries prefer to be treated by their first point of contact and by someone with whom they are familiar, to being referred onward.

Incentives for Performance To reinforce the family doctor's practices and to discourage her from referring patients onward when she is capable of treating them, incentive payments or bonuses may be instituted. Such payments reward the performance of preventive activities and attempts to treat patients before referring them. In parallel, disincentives may be put in place to discourage referrals before treatment has been tried, when the patient's condition is within what the family practitioner has been trained for. Patients may be encouraged to seek treatment at primary care facilities staffed by family practitioners through charging them fees for self-referrals to specialists or hospitals.

Changed Pattern of Practice with Family Doctors Exhibit D1 shows how family practitioners can make the amount of care provided in primary-care ambulatory settings grow and that provided by specialists and in hospitals shrink. More patients are treated on first presentation at ambulatory primary care facilities, fewer are referred and fewer self-refer. This is shown by the difference in the thickness of the arrows representing patient flows between the upper (no family practitioners) and lower (family practitioners and accompanying incentives) diagrams.

Exhibit D1 also shows a reduction in home visits by family practitioners. In former-Soviet countries, doctors make many more home visits than do doctors in most other countries. In some cases, where the patient is unable to come to the primary care facility, there may be no alternative to a home visit. However, many of the home visits are made to the able-bodied. If the able-bodied were to come to the primary care facility for treatment there would be savings in fuel and maintenance of the vehicles used to transport the doctor and the doctor would have more time to devote to seeing other patients, instead of spending time in travel. Able-bodied patients may be encouraged to come to the primary care facilities, rather than being treated at home, by charging them a modest fee for home treatment, while offering treatment at the primary care facility at a lower or no charge. The reduction in home visits to the able-bodied with the introduction of a charge for them is shown in Exhibit D1, as well.

The result of the changed pattern of care from using family practitioners is a lower cost for providing high-quality, consumer-responsive health services. This is shown in Exhibit D1 by the smaller cost rectangle once family practitioners and the incentive programs are put in place.

How Costs are Saved Exhibit D2 makes more explicit the cost savings from the institution of family practitioners and the accompanying incentives. The rectangle on the left of the top diagram represents the sum of the illnesses in the population before the institution of family practitioners and related incentives. The segments of the left rectangle represent the breakdown of how the illnesses are handled. Some are treated at home, others at the primary-care facility. Many are referred to hospitals and specialists, many more self-refer without coming to the primary-care facility.

The rectangle on the right represents the cost of treating the population's illnesses. Those treated by specialists, in hospitals, or at home have a higher cost per treatment than those treated at the primary-care facility.

The lower diagram represents how the situation can be expected to change when family practitioners and incentives for performance are put in place. The preventive activities of the family practitioners result in fewer illnesses and treatment at an earlier stage of illness. Hence the left-hand rectangle representing the sum of illnesses is smaller by the illnesses prevented than the illnesses rectangle in the upper diagram. The preventive activities have a cost, however, so an additional segment is added to the cost rectangle in the lower diagram. Fewer people are treated at home, referred, or self-refer. Many more illnesses are treated by the family practitioner at the primary-care facility.

Consequently, the lower cost per treatment at the primary-care facility allows great savings to be realized. Prevented cases and illnesses detected and treated early also produce savings. The total of these savings are more than enough to make up for the additional expense of prevention activities. Hence, the total cost rectangle in the lower diagram is smaller than in the upper.

As shown at the lower right, some of the saved resources may be used to fund the incentive bonuses to reward prevention and appropriate treatment of illnesses at the primary-care facility. Saved resources also may be used to improve the quality of care by paying for improvements in primary-care laboratories, better counseling materials, and no-charge drugs for vulnerable populations, such as children and the elderly.

ANNEX E

MAP OF SKOLE RAYON

ANNEX H

DR. M.O. DASHYNYCH'S PERFORMANCE REPORT

ANNEX I

PRESS COVERAGE OF COWLEY-MAKINEN VISIT TO L'VIV MEDICAL UNIVERSITY